September 30, 2005

TO: Recipients of the King County Chemical Dependency (CD) Performance Indicator Report (PIR)

FM: Jim Vollendroff, Assistant Division Director/Drug and Alcohol Coordinator, King County Mental health, Chemical Abuse and Dependency Services Division

RE: July – December 2004 PIR

I am pleased to announce the publication of the CD PIR for the period of July – December 2004. We continue to work on issuing these reports closer to the timeframe covered by each report, and have made improvements on some of the technical barriers. For instance, we can now directly access data from the Sobering and Assessment Centers because of the work our Information System (IS) staff have done in designing the CD Integrated Database.

As with previous issues, the report provides data from six consecutive biennial quarters (a six month period) to allow for comparisons over time. However, due to changes in data collection requirements, the Prevention Programs are only represented for three quarters.

I want to draw your attention to the Summary Data that appears at the back of each issue. While the majority of the report depicts the performance of discrete programs, we are able to draw comparisons across programs in the summary section. This section also includes complete data from the 2002-04 CD Financial Plan, which we are only able to include in reports representing the final six months of a calendar year.

As most of you are aware, the 2005 Legislative Session resulted in significant increases in funding for CD services. It will be interesting to monitor how these increases impact changes to access and completion rates over time, and we will point out noteworthy changes in forthcoming issues.

I continue to solicit and welcome your feedback on both the format and content of the Performance Indicator Report. We want the information we are reporting to be useful and informative to all stakeholders, and your input has shaped the report since its inception. Please direct your comments to jim.vollendroff@metrokc.gov or call me at (206) 205-1312.

JV:LG:ran

King County

Mental Health, Chemical Abuse and Dependency Services Division

CHEMICAL DEPENDENCY PERFORMANCE INDICATORS REPORT

July – December 2004

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Introduction

The King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) developed the Chemical Dependency Performance Indicators Report (CDPIR) to provide the community with timely information about the publicly funded chemical dependency treatment delivery system in King County. This system serves adults and adolescents who do not have adequate resources to pay for treatment and support services.

This is the fifth edition of the CDPIR. We consider this to be a work in progress. Changes to the format and content will evolve as we identify ways to make the report more meaningful and useful to the reader. MHCADSD will utilize the data to identify and implement changes to enhance the chemical dependency treatment delivery system in King County. We welcome your feedback and suggestions on the usefulness of the information presented as well as comments on the content and format of the document.

The CDPIR includes:

- Data for a three year period for each program funded by MHCASDSD
- Summary program and demographic data for the most recent calendar year
- Appendices that provide detail about the data, define terms used and list the agencies that provide the programs and services included in this report.

Data for all program areas are presented by biennial quarter: January 1 – June 30; July 1 – December 31. **[Note: Charts use the following labels for biennial quarters: "1H01" means January through June of 2002; "2H01" means July through December 2002, etc.]**

In most program areas, ethnicity data for people who participate in services are shown, but only for the last biennial quarter in the report period. Only one time period is shown because the complexity and ambiguity of the data make it impossible to draw a clear and accurate picture over the three years covered in this report. See Appendix A for details.

The CDPIR is issued twice a year. The next report, for January–July 2005, will be published in late 2005.

In addition to the services provided through MHCADSD and Public Health – Seattle & King County (Public Health)[1], the Division of Alcohol and Substance Abuse (DASA) directly contracts with King County providers for certain services, such as residential treatment. Information about those services is not included in this report, but can be found at http://www1.dshs.wa.gov/dasa/overview.shtml.

[1] Public Health contracts for Prevention programs; MHCADSD provides or contracts for all other programs included in this report.

Chemical Abuse and Dependency Programs

Prevention

The target populations for drug and alcohol prevention programs are children, youth and parents. Programs are designed to prevent or delay first use and abuse of alcohol and other drugs by reducing risk factors and enhancing protective factors.

Through a required public process, four risk and protective factors were targeted for King County for the period of July 2003 through June 2005. They are:

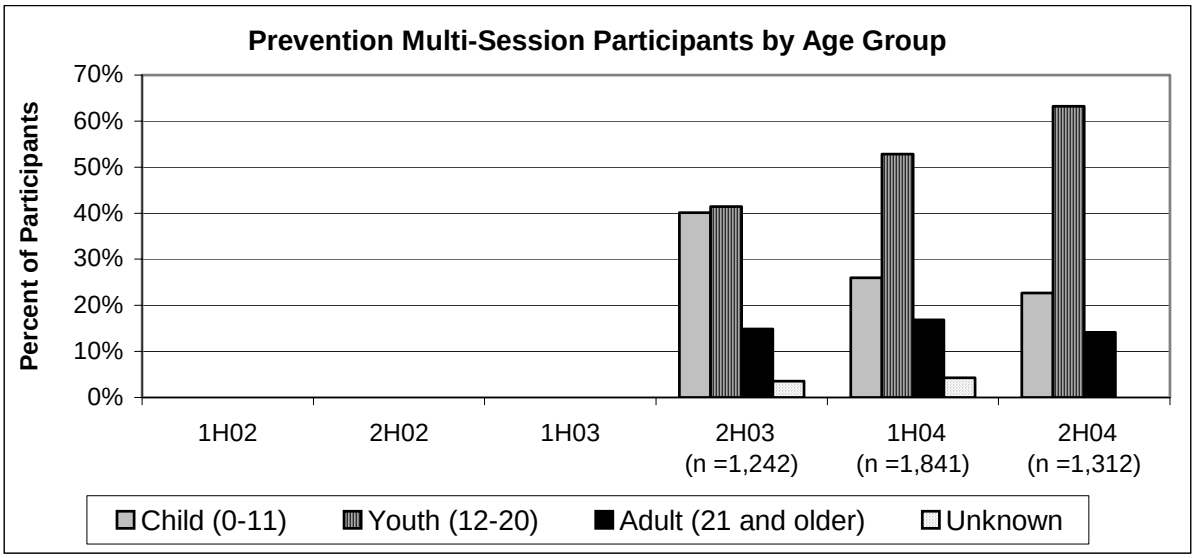
- Favorable attitudes among youth that encourage substance use (risk factor)
- Family management problems due to inconsistent guidelines for behavior and inappropriate rewards and consequences for following and not following guidelines (risk factor)
- Warm, supportive relationships with parents, teachers, other adults and peers (bonding) who reinforce competence, expect success and support not using alcohol, tobacco or other drugs (protective factor)
- Healthy beliefs and clear standards that oppose teenage use of illegal drugs and alcohol (protective factor)

Risk and protective factors are addressed through single event or multiple session programs. Single event programs during the biennial quarter were:

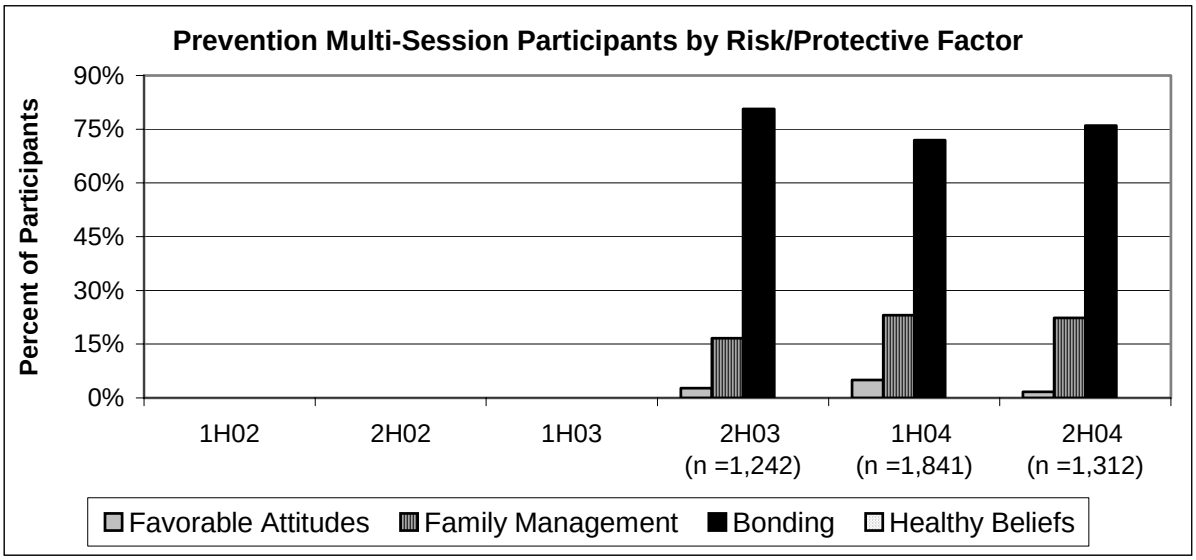
- panel presentations that targeted family management problems and reached 405 parents and
- prevention summits or conferences that targeted bonding and reached 72 youth.

Prevention programs that have a multiple session format, such as skills training classes or support groups, collect demographic data about participants. Only multi-session programs are included in the following graphs. Because a new system for collecting prevention data was implemented in July 2003, only three biennial quarters of data are available for this report.

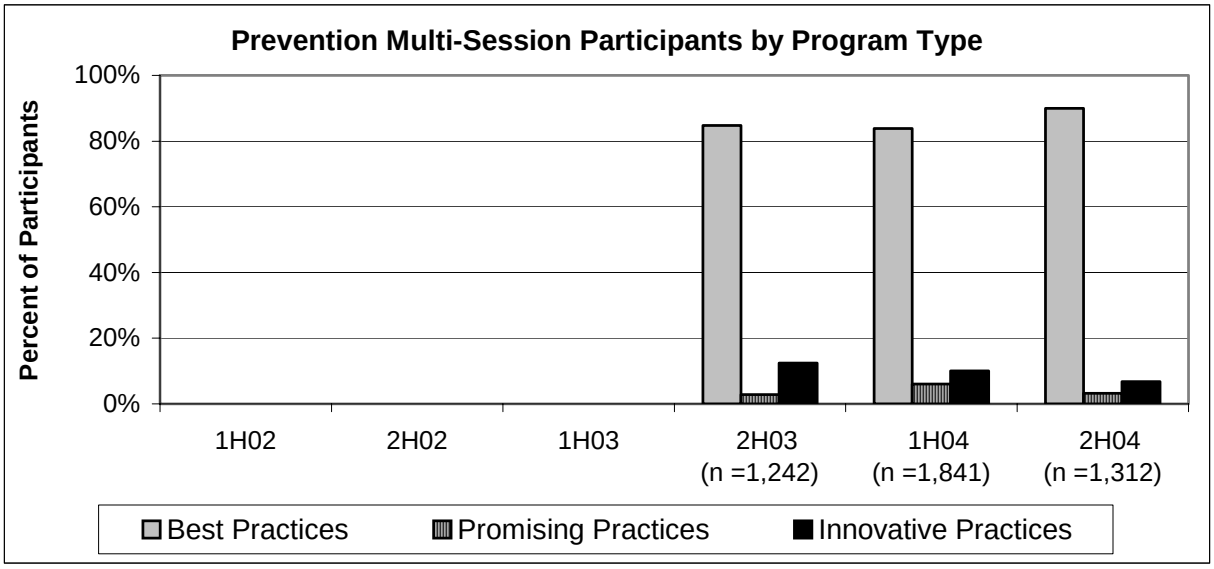
The following graph shows the number of participants by biennial quarter and age group.



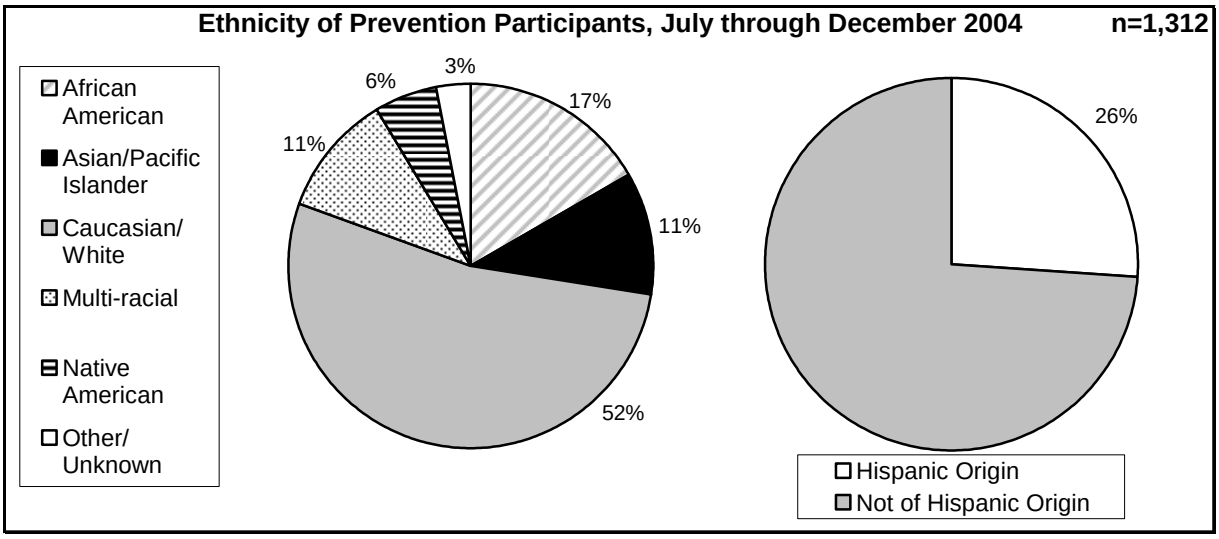
The following graph shows the number of participants by the risk or protective factor that is targeted by the program.



Research has validated the effectiveness of some prevention efforts while others have yet to be evaluated. Applying this research, programs funded in King County are categorized as "best practices", "promising practices" or "innovative practices". The following graph shows the number of participants by biennial quarter and program type.



The charts below show the ethnicity of people who participated in multi-session prevention programs from July though December 2004.

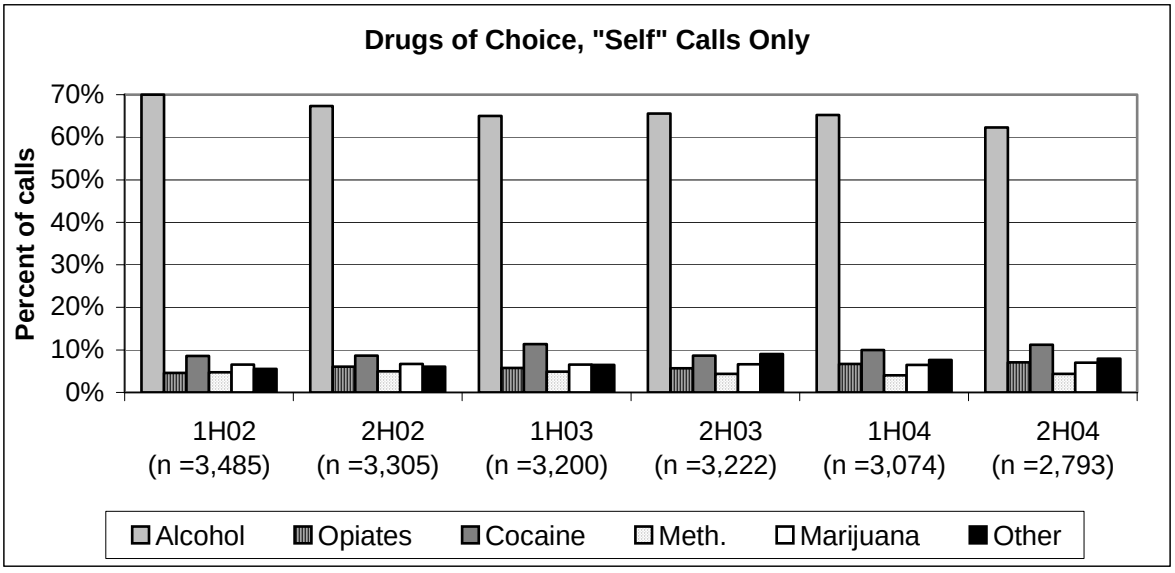


Alcohol/Drug 24-Hour Help Line

The Alcohol/Drug 24-Hour Help Line provides telephone crisis intervention and information and referral services.

Although the Help Line is a statewide service, data presented are limited to callers from King County. The Help Line responds to all calls for information about drug and alcohol use, regardless of caller eligibility for publicly funded treatment.

In the chart and table below, "Self" refers to persons who are calling about themselves, "Other" reports persons calling on behalf of another person. Because of concerns about accuracy with "Other" calls, "Drugs of Choice" data are presented for self calls only. More than one substance may be reported per call.



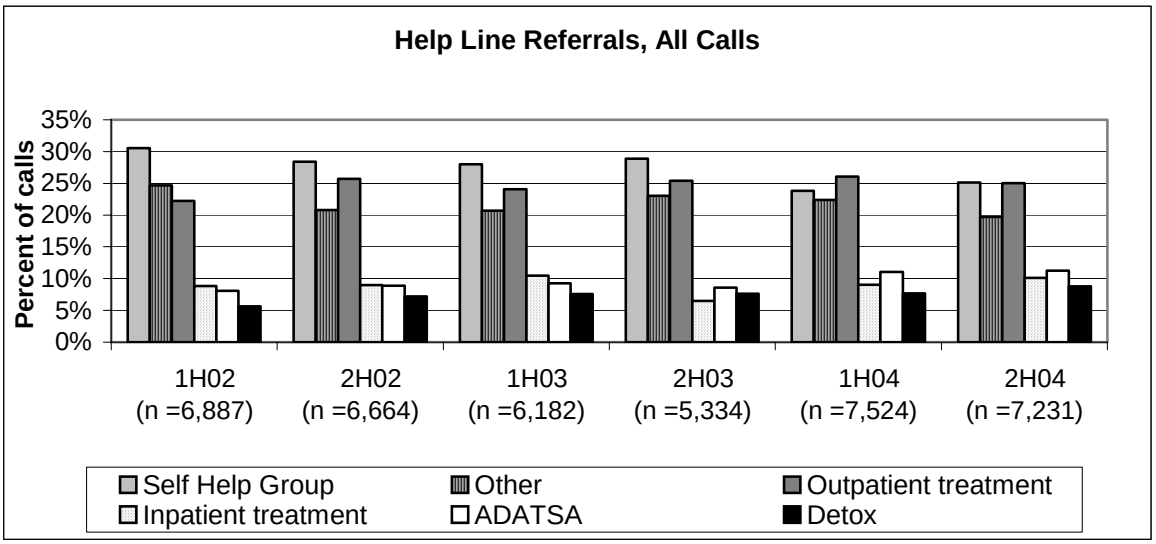
For the last two biennial quarters, prescribed pain pills have been 3-4% of drugs reported. Those are included in "Other".

Although limiting the data to "Self" calls provides better information about substances being used by callers, 90% of those calls are about adult use (as shown in the table below). This means that the predominance of alcohol as the drug of choice primarily reflects adult use. Other data (see the Outpatient Youth and Adult drug of choice charts) suggest a significant difference between adult and teen drugs of choice.

Reported Age Group, 2004

	Self		Other		All	
Age of subject of call	**#**	**%**	**#**	**%**	**#**	**%**
Teens & younger	280	10%	752	26%	1,032	18%
Adults (20 - 60)	2,509	87%	2,118	72%	4,627	79%
Older adults (over 60)	92	3%	75	3%	167	3%
All ages	**2,881**	**100%**	**2,945**	**100%**	**5,826**	**100%**

Referrals made by the Help Line are shown in the chart below. More than one referral may be made per call. "Other" includes referrals to medical, housing, domestic violence, legal, mental health, involuntary CD treatment, emergency and police resources. Referrals made to providers of outpatient chemical dependency treatment include both privately and publicly funded services.

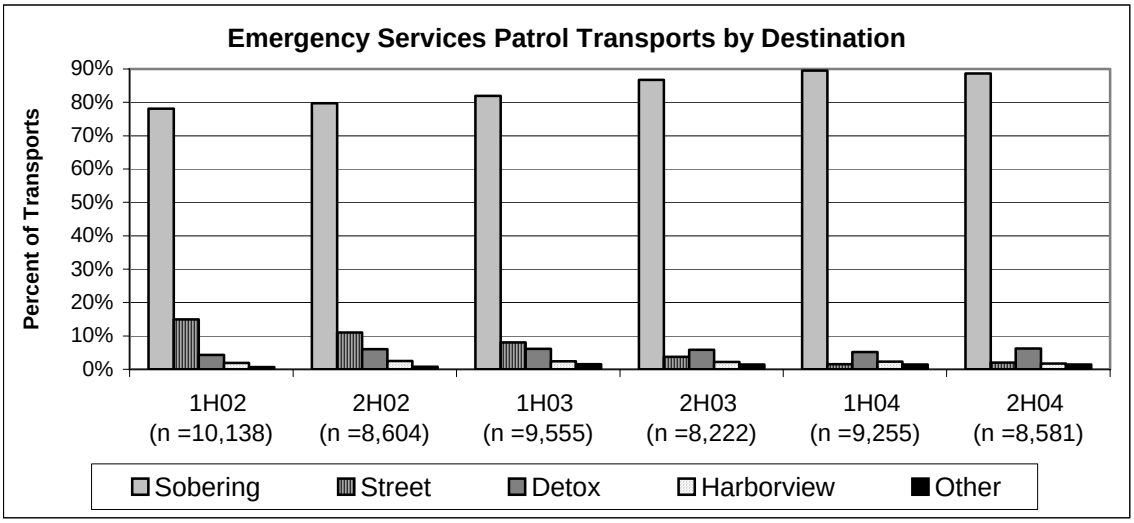


Self Help Group is no longer the resource that is most frequently suggested. During 2004 more referrals were made to CD outpatient treatment than to self help groups.

Although the total percentage for "Other" referrals is large, no single area represents more than 3% of all referrals.

Emergency Services Patrol

The Emergency Services Patrol (ESP) provides direct assistance and transport of intoxicated/incapacitated individuals to appropriate services and treatment from designated areas within the City of Seattle, 24 hours a day, seven days a week.



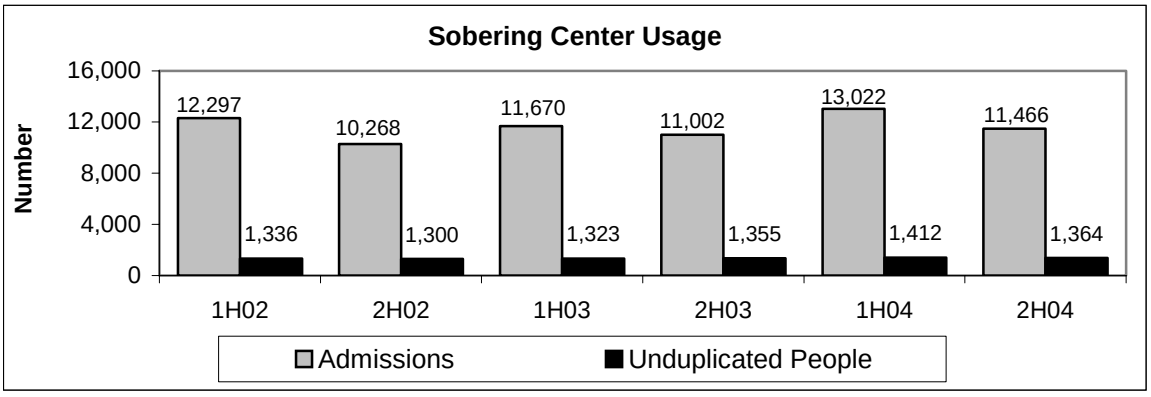
The decrease in the percentage of transports to the "Street" and increase in percentage of transports to the Sobering Center reflects a change in practice at the Sobering Center. Clients used to be awakened early in the morning; groups of clients were then transported back to the streets. More recent practice has been to let clients sleep until they wake up, at which time, most people walk away from the Center with no transport. From 2002 to 2004 the total number of transports decreased by 5%, but the number of transports to the Sobering Center grew by 8%. That is, in addition to the increase in the percentage of transports to the Sobering Center that was noted in previous quarters, there has been an increase in the last year in the number of transports to the Sobering Center.

It is not possible to collect reliable demographic data about ESP clients. However, because a majority of transports are to the Dutch Shisler Sobering Center (Sobering Center), the demographic data from the Sobering Center provide a good approximation of ESP client demographics.

Dutch Shisler Sobering Center

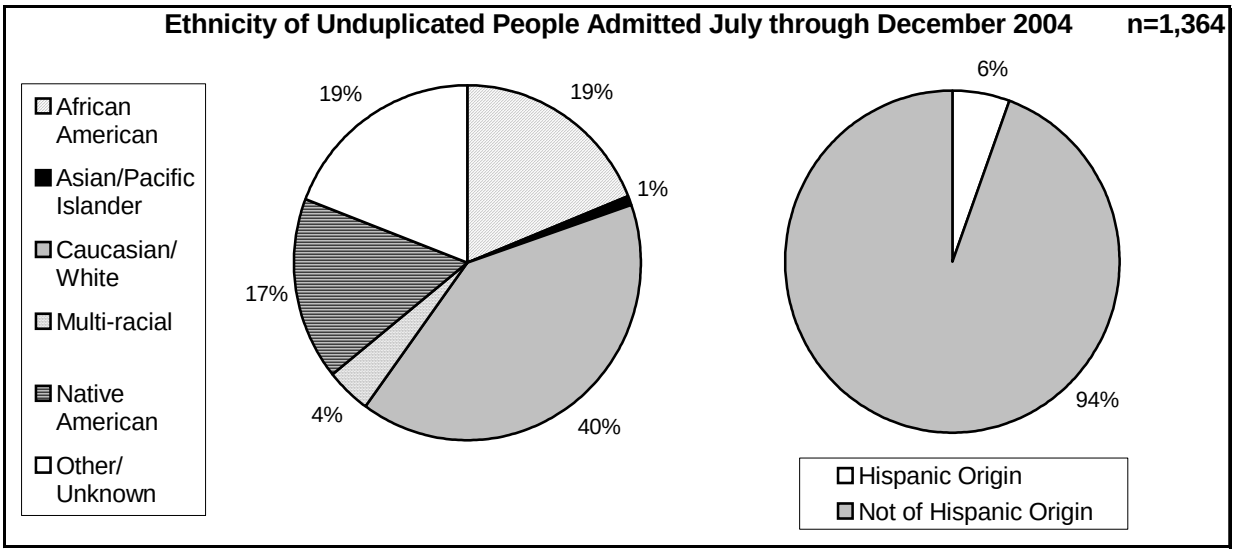
The Dutch Shisler Sobering Center provides adults a safe and secure place to recover from the effects of acute intoxication by alcohol and/or other drugs. Clients receive a medical screening and are referred to treatment and other appropriate services.

The chart below shows the numbers of admissions to the Sobering Center and the number of unduplicated people who were admitted.

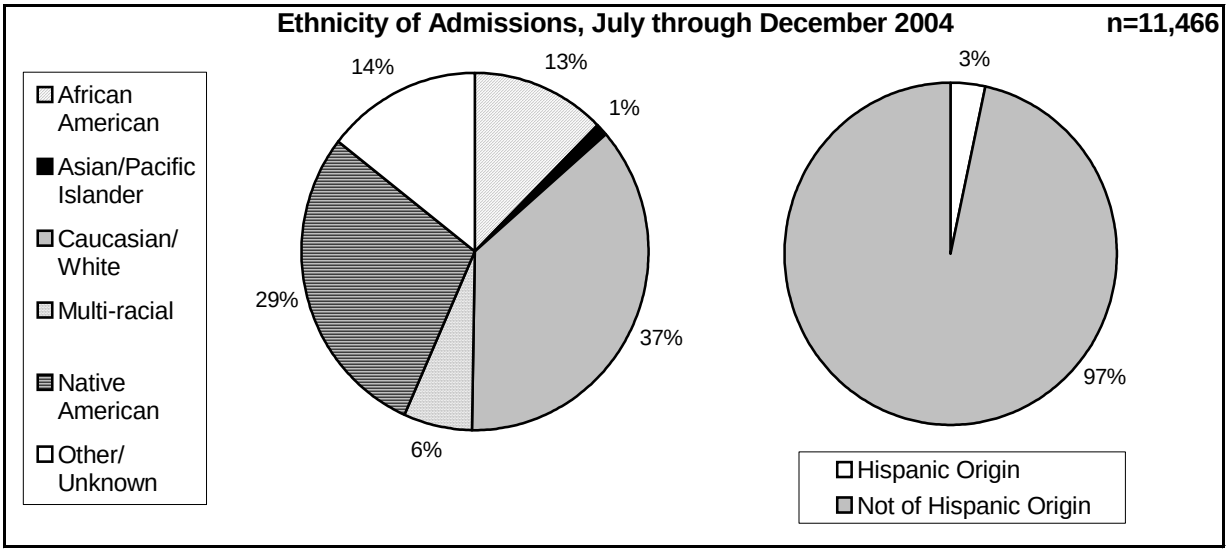


From the data above, it is clear that some individuals are multiple users of the Sobering Center. In the last biennial quarter, 8% (113) of the 1,364 people admitted accounted for 65% of the total admissions. These 113 individuals averaged 66 admissions each during the six-month period, with a range from 25 to 192 admissions.

The following charts show the ethnicity of unduplicated people served by the Sobering Center from July through December 2004. See Appendix A for additional details.



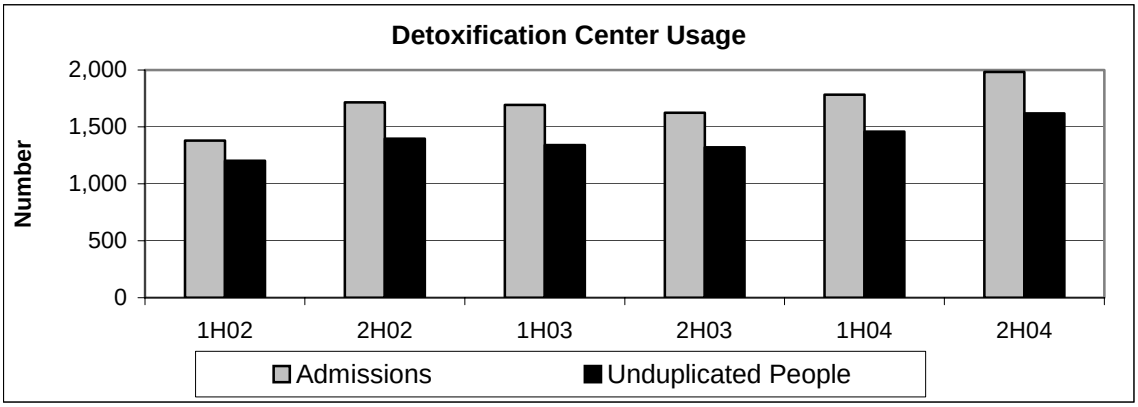
The proportion of people who receive services from the Sobering Center who are Native American is much higher (17%) than the proportion in either the general population (2%) or in any other drug/alcohol program area (see Summary Data, Demographic Detail). In addition, a disproportionate number of the multiple users of the Sobering Center are Native American. Among those admitted more than five times in the last biennial quarter, 29% were Native American. As shown in the charts below, 29% of all admissions to the Sobering Center are for Native Americans although they are only 17% of the individuals served.



Detoxification Center

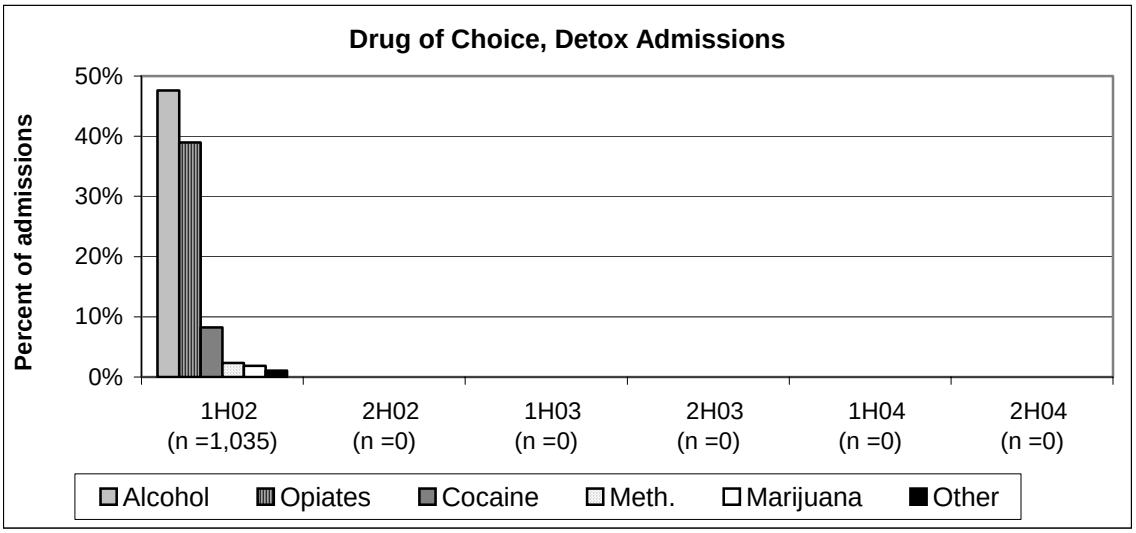
Detoxification services are provided to indigent clients who are recovering from the effects of acute or chronic intoxication or are withdrawing from alcohol or other drugs. Upon successful completion of detoxification services, clients are referred for ongoing treatment and support.

The chart below shows the number of new admissions to the Detoxification Center during each biennial quarter and the number of unduplicated people admitted.



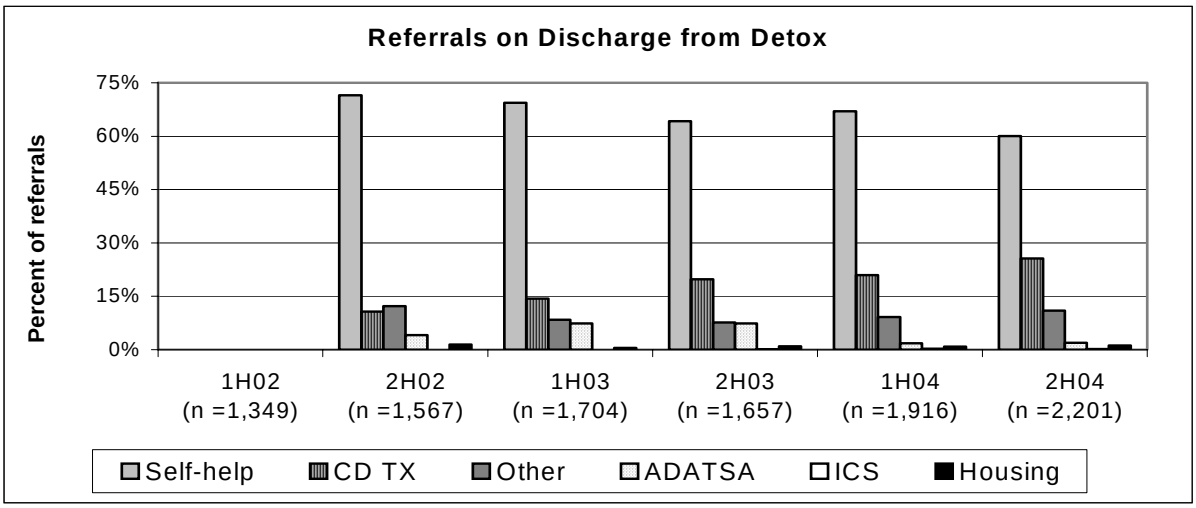
Since the second half of 2002, there has been a sustained increase from previous biennial quarters in the numbers of admissions and people served. This coincides with efforts by MHCADSD to increase the number of people served by the Detoxification Center.

The following chart shows the primary substance used by people admitted to the Detoxification Center; this isn't necessarily the substance for which detoxification is needed (see Appendix A for more information).



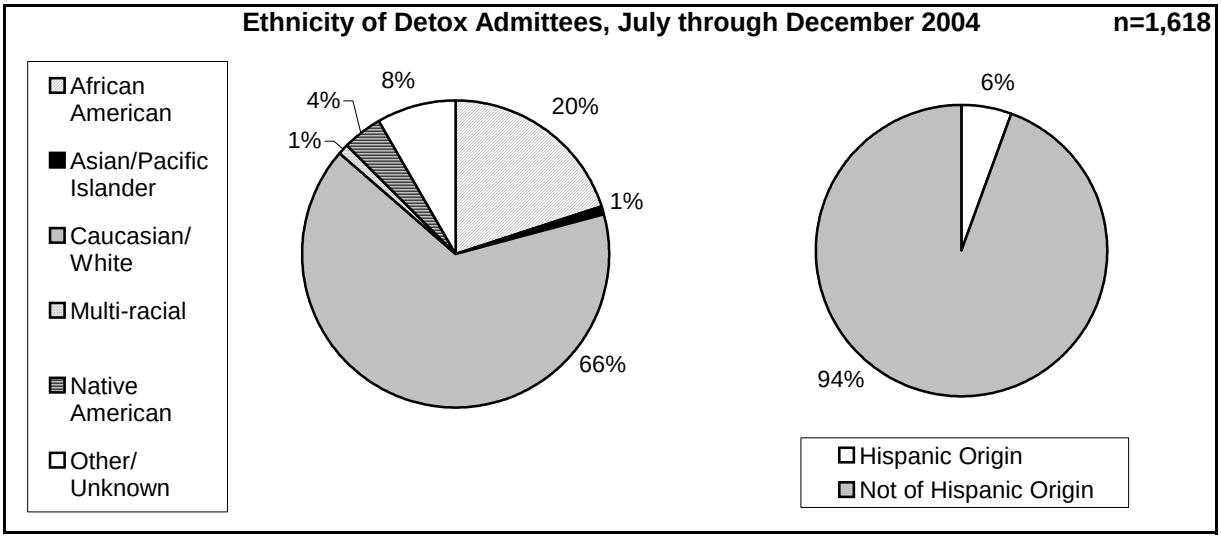
Because alcohol and opiates are substances much more likely to require a medically managed detoxification, their predominance here is not surprising. Data for June 2002 through December 2004 were not available for this report.

The chart below shows the resources to which people were referred when discharged from the Detoxification Center, based on the biennial quarter of the discharge.



Referral data for detoxification were severely affected by changes in 2001 and 2002 to the DASA data collection system (TARGET, see Appendix A). As a result, data prior to July 2002 are not comparable to data since then and are not shown here.

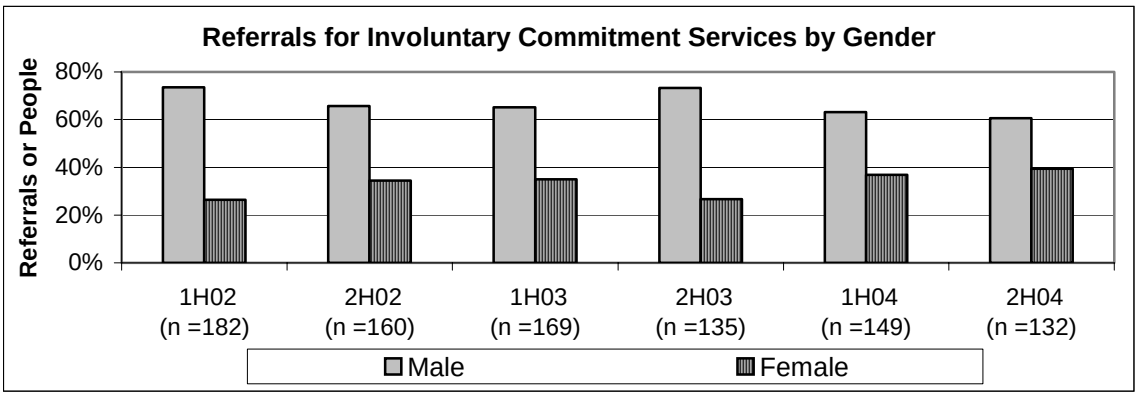
The charts below show the ethnicity of unduplicated people admitted to the Detoxification Center from July through December 2004. See Appendix A for additional details.



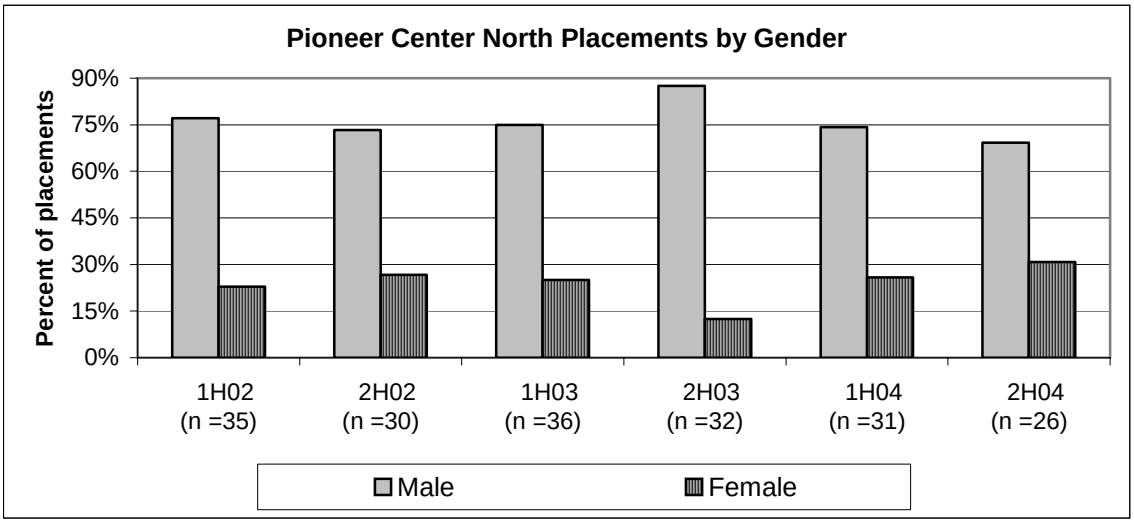
Involuntary Commitment Services

Involuntary Commitment Services (ICS) include investigation and evaluation of facts to determine whether a person is incapacitated as a result of chemical dependency. If a chemical dependency specialist determines there is reliable evidence to support a finding of incapacity, a petition for commitment can be filed on behalf of the incapacitated person. Courts can then commit a person to a locked treatment facility for intensive treatment.

The following chart shows referrals received for investigation by gender.



Most of the referrals that result in commitments lead to a placement at Pioneer Center North (PCN) for inpatient treatment. The chart below shows the proportions of males and females among those referred to ICS who were placed at PCN for treatment.

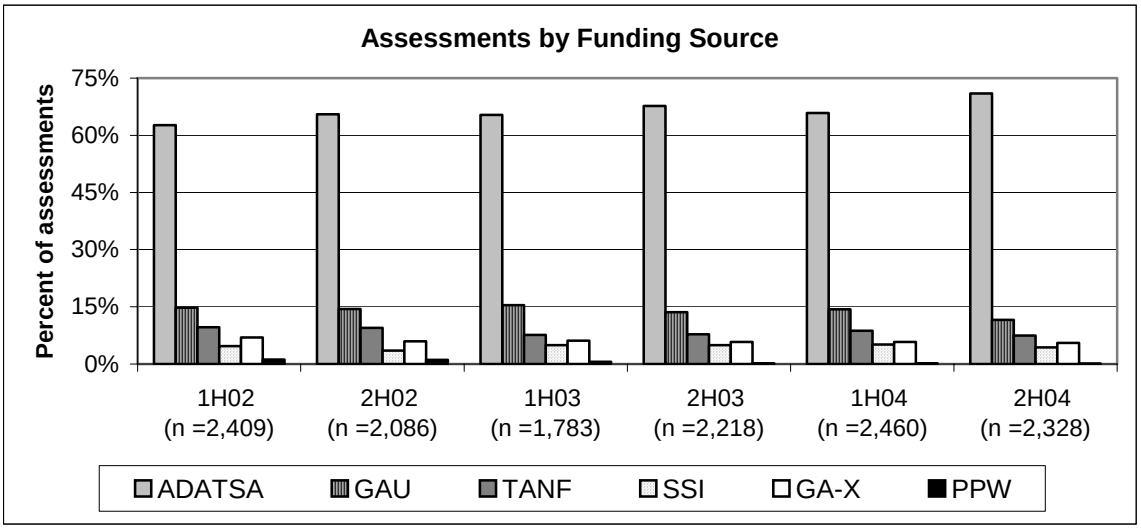


From July through December 2004, 39% of people referred to ICS were female and 31% of PCN placements were for females.

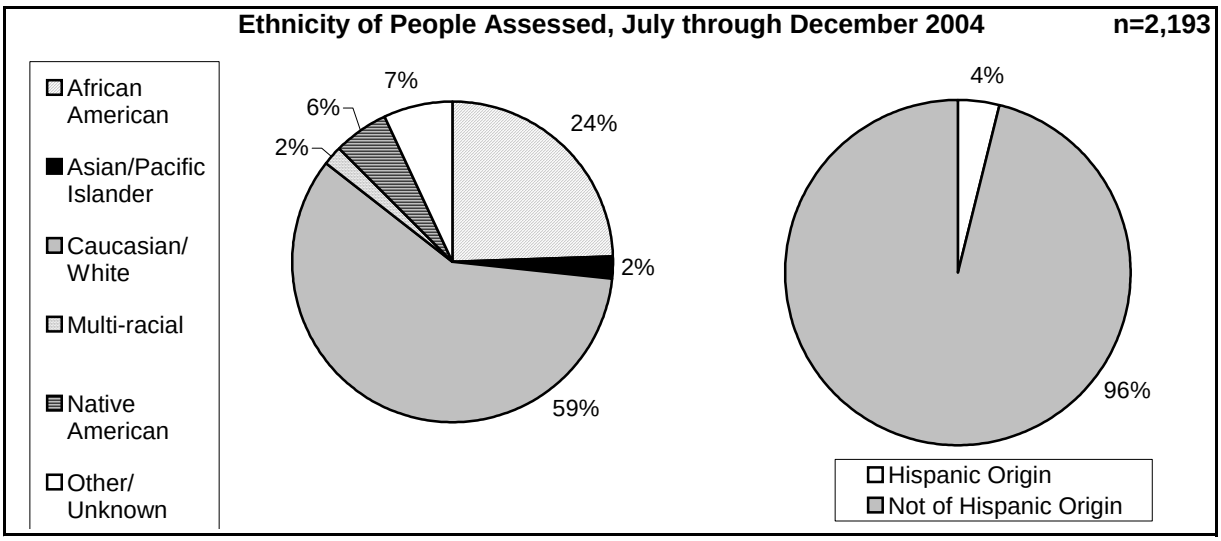
Assessment Center

The Assessment Center determines eligibility for treatment funded through public funding sources. These include the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), General Assistance Unemployable (GAU), Temporary Assistance for Needy Families (TANF), Social Security Income (SSI), General Assistance – Expedited Medicaid (GA-X) and Pregnant and Postpartum Women (PPW). TANF, SSI, GA-X and PPW are Medicaid programs. (See Appendix B for information on these funding sources.)

The following chart shows the proportion of assessments by the funding source for which the person assessed was eligible.



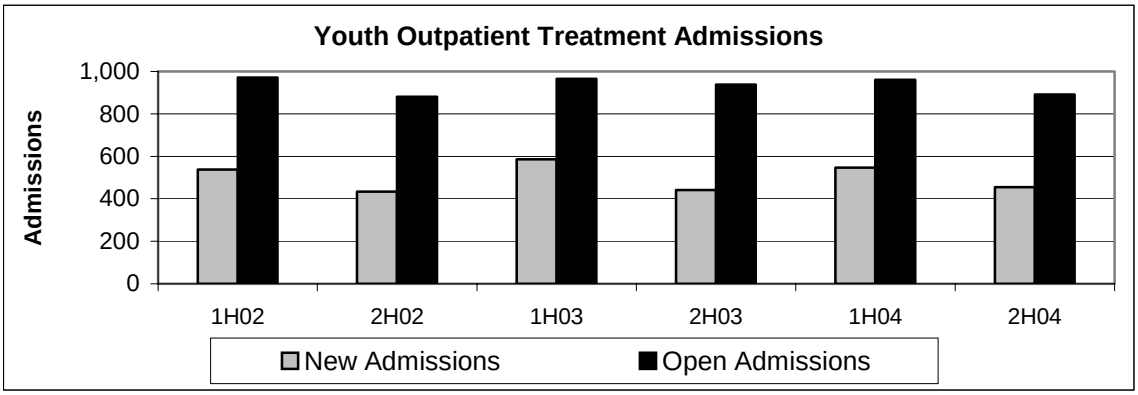
The charts below show the ethnicity of unduplicated people assessed from July through December 2004. See Appendix A for additional details.



Outpatient Treatment - Youth

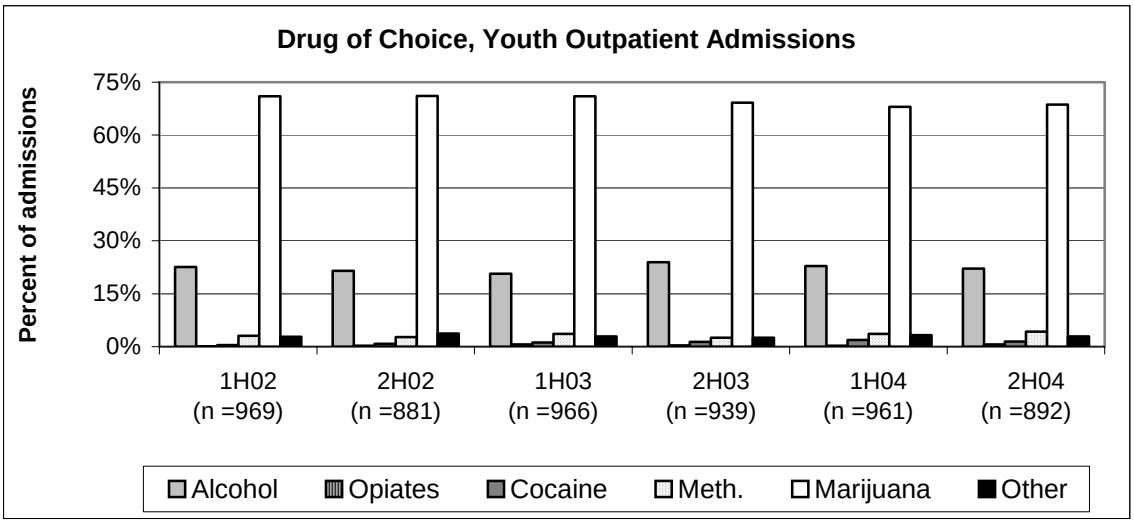
Outpatient treatment services for youth and young adults are targeted for low-income and indigent youth. Services include development of sobriety maintenance skills, family therapy or support, case management and relapse prevention. Services are expected to improve school performance and peer and family relationships and to decrease risk factors associated with substance use and abuse.

The following chart shows admissions to outpatient treatment for youth under 18. Both "new admissions", which started during the biennial quarter, and "open admissions", which include people who started treatment prior to the start of the quarter and were not yet discharged, are shown.



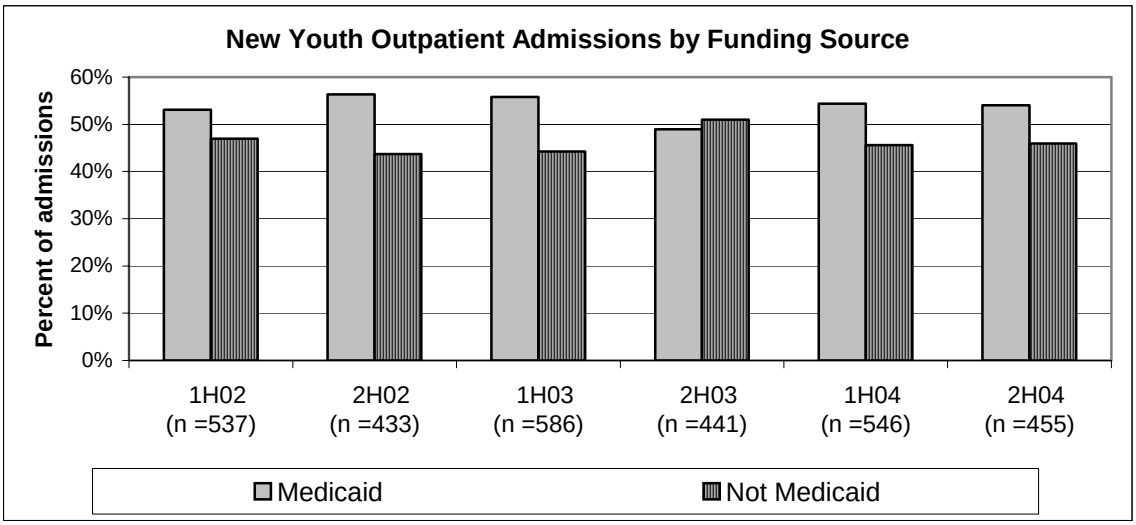
Historically, youth treatment admissions have fluctuated in relation to the school calendar because schools are a major source of referrals. Referrals, assessments and admissions are lower in July, August and December and consistently higher from January through June.

The chart below shows the primary substance used by youth admitted to outpatient treatment.

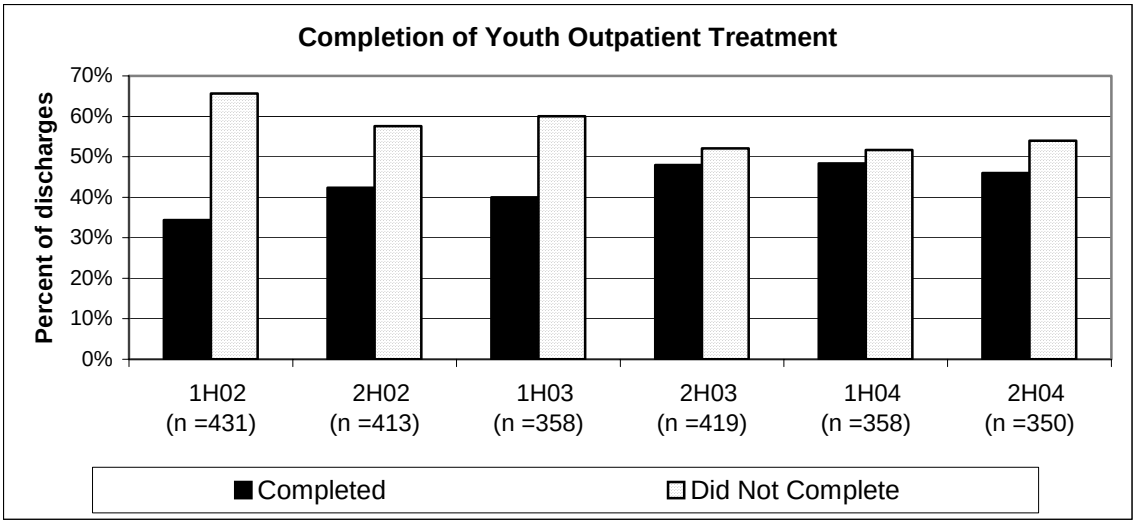


While the most frequently used drug among youth in treatment is marijuana, a significant percentage of youth are using alcohol.

The chart below shows the proportion of newly admitted youth each biennial quarter whose treatment is funded by Medicaid vs. other public funding.

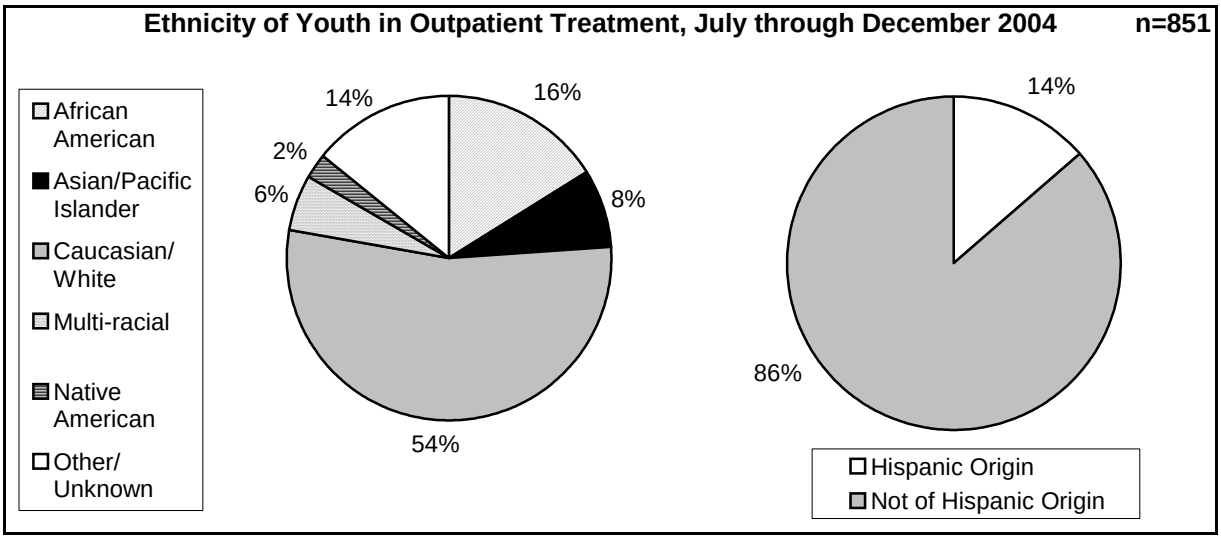


The following chart shows rates for successfully completing treatment for youth who were discharged during the quarter. (See Appendix A for details on how the rate is determined.)



The statewide completion rate, excluding King County, for youth outpatient treatment for 2004 was 38% compared to 47% for King County.

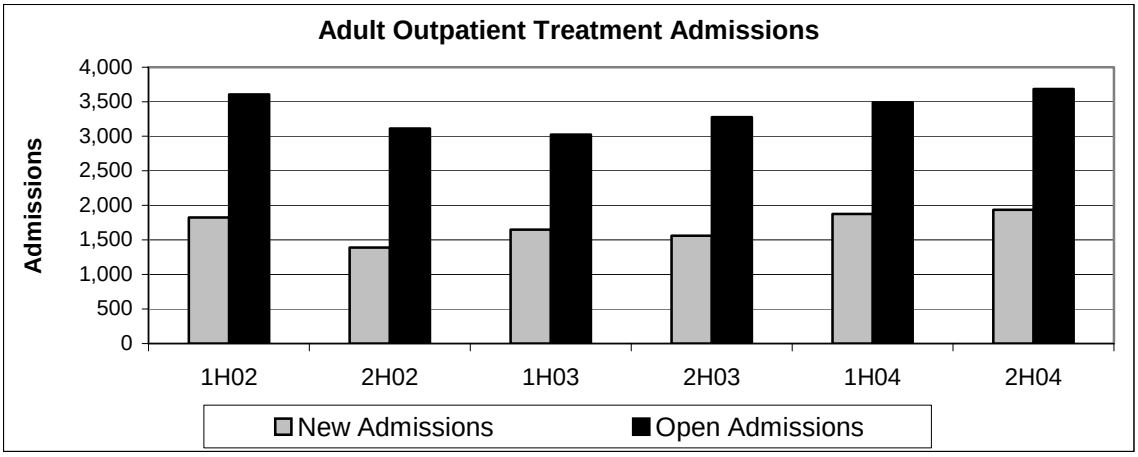
The charts below show the ethnicity of unduplicated youth receiving outpatient treatment from July through December 2004. See Appendix A for additional details.



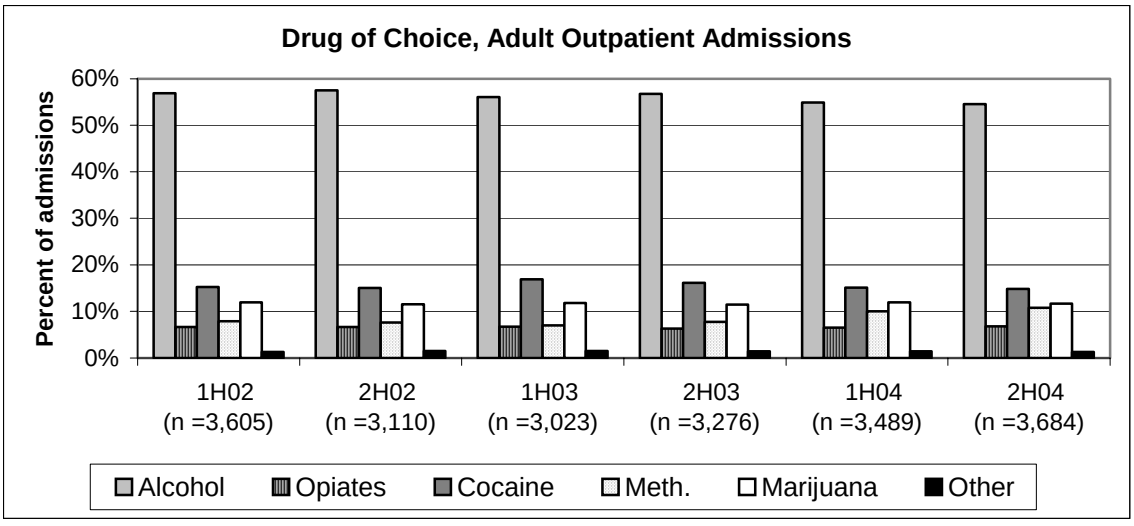
Outpatient Treatment - Adult

Outpatient treatment services provide treatment to low-income and indigent adults who need treatment to recover from addiction to drugs and/or alcohol. Services are designed to assist clients to achieve and maintain sobriety, and can include individual face-to-face treatment sessions, group treatment, case management, job-seeking motivation and assistance, or other services, including referrals to appropriate service agencies.

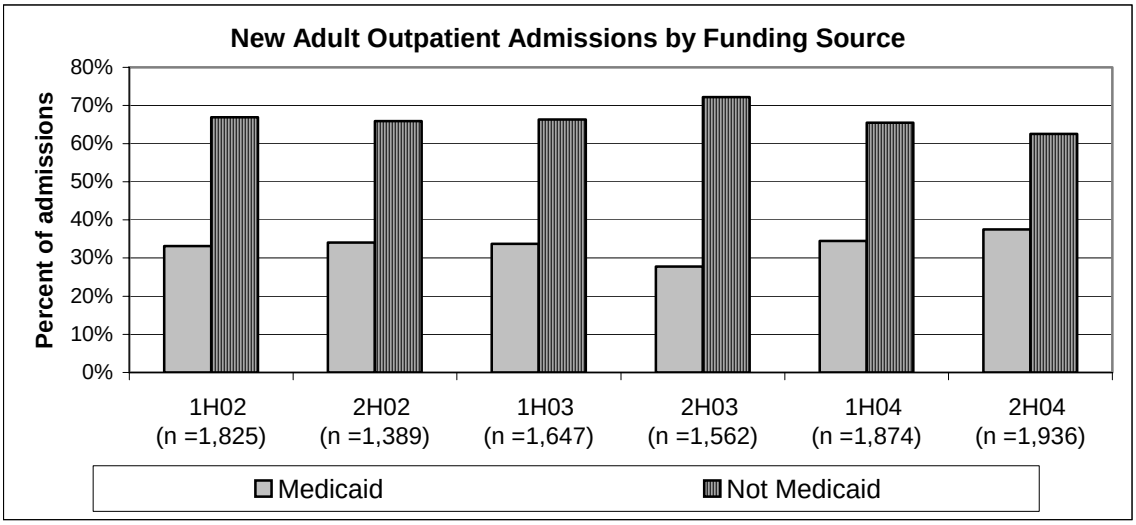
The following chart shows admissions to outpatient treatment for adults, 18 and over. Both "new admissions", which started during the biennial quarter, and "open admissions", which include people who started treatment prior to the start of the quarter and were not yet discharged, are shown.



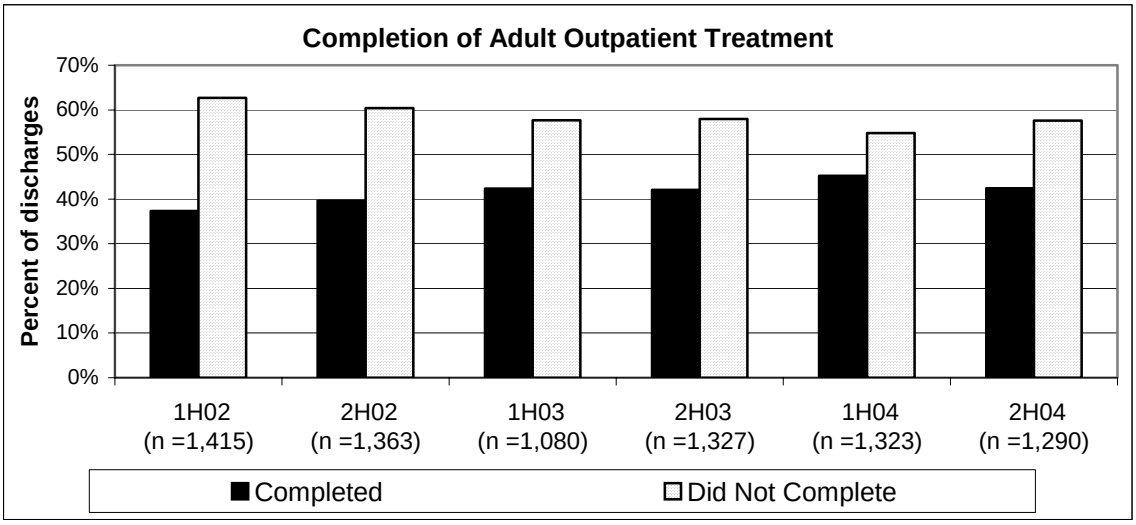
The chart below shows the primary substance used by adults admitted to outpatient treatment.



The following chart shows the proportion of newly admitted adults each biennial quarter whose treatment is funded by Medicaid vs. other public funding.

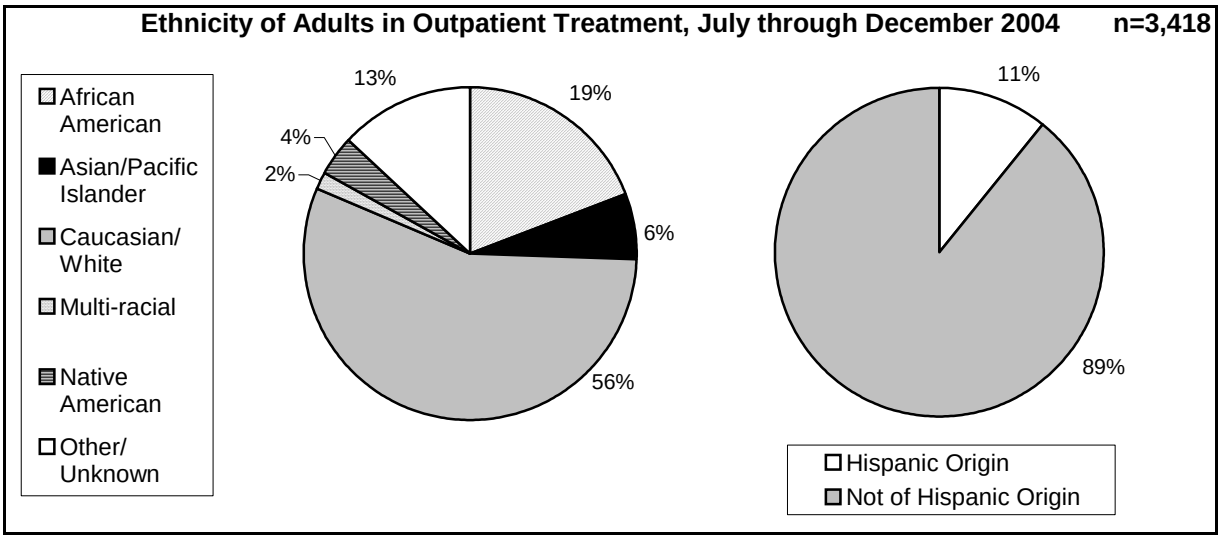


The chart below shows rates for successfully completing treatment for adults who were discharged during the quarter. (See Appendix A for details on how the rate is determined.)



The statewide completion rate, excluding King County, for adult outpatient treatment for 2004 was 45% compared to 44% for King County.

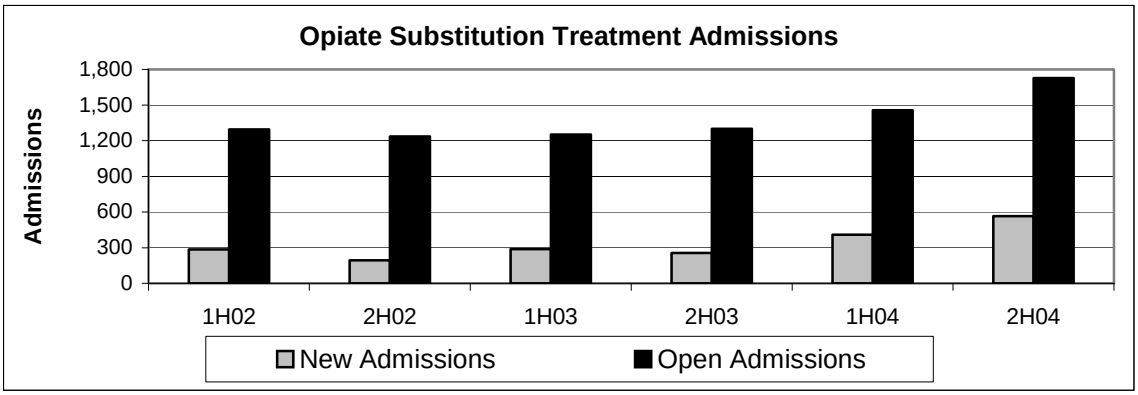
The charts below show the ethnicity of unduplicated adults receiving outpatient treatment from July through December 2004. See Appendix A for additional details.



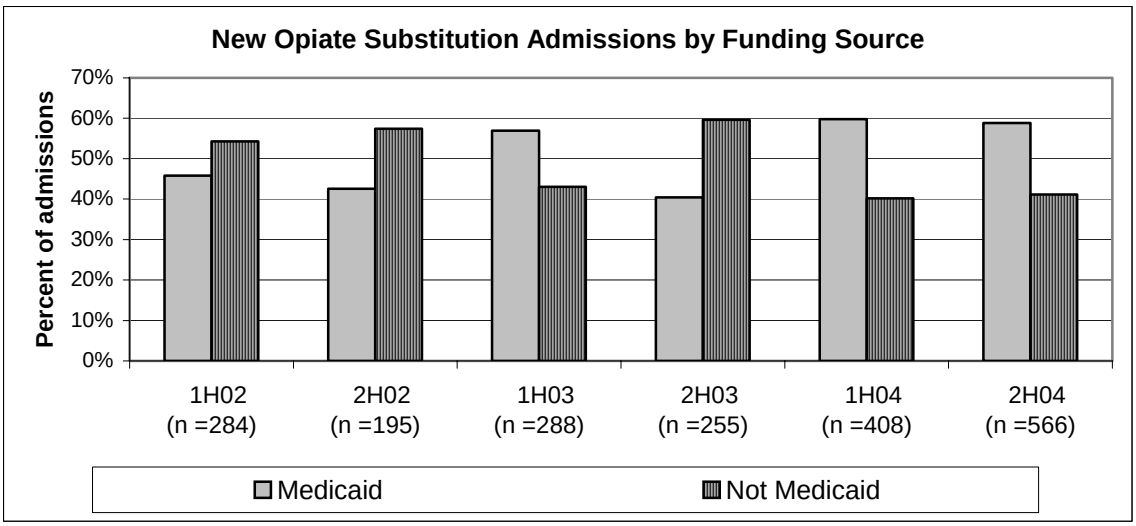
Opiate Substitution Treatment

Opiate substitution treatment programs provide medically supervised treatment services to persons with chronic opiate addictions. In addition to physical exams and medical monitoring, clinics provide individual and group counseling, medications, urinalysis screening, referral to other health and social services, and patient monitoring.

The chart below shows admissions to opiate substitution treatment. Both "new admissions", which started during the biennial quarter, and "open admissions", which include people who started treatment prior to the start of the quarter and were not yet discharged, are shown.

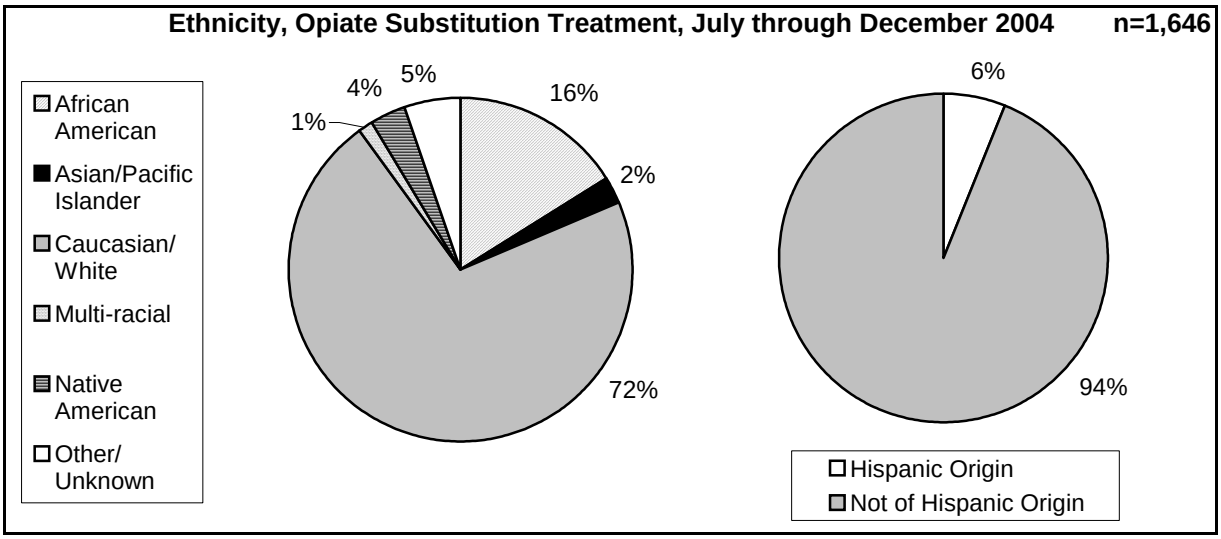


The following chart shows the proportion of newly admitted people each biennial quarter whose opiate substitution treatment is funded by Medicaid vs. other public funding.



The sharp increase in the last two biennial quarters in the percentage of new admissions funded by Medicaid is the result of additional Medicaid funding for opiate substitution treatment that became available in early 2004. The increases in both new and open admissions result partly from that funding and partly from additional low income funding that also became available in early 2004.

The following charts show unduplicated people receiving opiate substitution treatment from July through December 2004. See Appendix A for additional details.



Summary Data

Overview

This section provides summary data for the current calendar year in two areas:

- Services and dispositions
- Demographics of individuals served

It also provides summary data for the last three calendar years for financial revenues and expenditures.

The services data are for the same program areas and measures that were presented graphically in the Programs section. The time period that the data describe is different. Data in this section are for the most recent calendar year, which is the same time period as the last two biennial quarters shown in the charts. Both numbers and percentages are shown. See Appendix A for additional details.

The demographic data are broader than the data in the Programs section. For each area where data on unduplicated individuals are available (that is, all areas except the Alcohol/Drug 24-Hour Help Line and Emergency Services Patrol), the gender, race or ethnic group and Hispanic origin status of all individuals served during the most recent calendar year is reported. Both numbers and percentages are included. For Prevention, demographic data are shown only for participants in multiple episode programs.

To provide additional context, census data for gender and ethnicity in the youth and adult populations in King County that are below the federal poverty level are shown beside the program demographic data. Although many people with somewhat higher incomes also qualify for public funding, this data approximates the gender and ethnic mixtures among King County residents who are eligible for publicly funded services. Data for the "Youth Outpatient" programs should only be compared to the "Youth" population. All other programs except Prevention serve only adults. (Data provided by: Public Health- Seattle & King County, Epidemiology, Planning and Evaluation Unit. Data Source: 2000 Census, SF3 tables.)

The financial data include a financial plan for 2002, 2003, and 2004 Actuals. The financial plan shows the beginning fund balance, revenues received by type of revenue, expenditures made by category of expenditure, and the ending fund balance. The chart at the bottom of the page shows contracted expenditures for outpatient treatment services in 2002, 2003 and 2004. The chart is broken out by outpatient treatment services for adults and youth, and opiate substitution treatment services. Contracted outpatient services accounted for $6,827,446 in 2002, $6,079,232 in 2003 and $7,845,905 in 2004.

Title XIX (Medicaid) dollars are not included in the Financial Plan figures. Title XIX dollars combine state and federal funds to pay for treatment services. Money is set aside from the MHCADSD biennium contract with the State and allocated to chemical dependency treatment agencies to provide treatment services. These dollars are then matched with federal dollars and disbursed by the State directly to agencies for treatment services provided to Medicaid recipients. $2,342,305 were set aside for 2004. For 2004, the Title XIX County Summary Match Report shows that $4,805,421 total dollars were paid to agencies for the treatment services delivered. That is an increase from the amounts in 2003 of about $325,000 in the dollars set aside and an increase of about $565,000 paid for treatment.

Services and Dispositions, January – December 2004

	Number	Percent
Prevention Participants	2,959	100%
Age Group		
Child	734	25%
Youth	1,754	59%
Adult	471	16%
Unknown	0	0%
Risk/Protective Factor		
Favorable Attitudes	106	4%
Family Management	639	22%
Bonding	2,214	75%
Healthy Beliefs	0	0%
Program Type		
Best Practices	2,498	84%
Promising Practices	150	5%
Innovative Practices	311	11%
Alcohol/Drug Help Line Calls		
Drug of Choice (about self only)	5,867	100%
Alcohol	3,744	64%
Opiates	403	7%
Cocaine	620	11%
Methamphetamines	247	4%
Marijuana	395	7%
Other	458	8%
Referrals (all calls)	14,755	100%
Self help group	3,608	24%
Other	3,113	21%
Outpatient treatment	3,771	26%
Inpatient treatment	1,409	10%
ADATSA	1,642	11%
Detox	1,212	8%
ESP Transports, All Destinations	17,836	100%
Sobering	15,897	89%
Street	314	2%
Detox	1,017	6%
Harborview	357	2%
Other	251	1%
Sobering Center Admissions	24,488	
Unduplicated People	2,245	
Detoxification Center		
Admissions	3,766	
Unduplicated People	2,770	
Admissions by drug of choice		
Alcohol		
Opiates	***Data not***	
Cocaine	***yet available***	
Methamphetamines	***for 2004***	
Marijuana		
Other		
Referrals on discharge, all d/c	4,117	100%
Self-help	2,605	63%
CD TX	967	23%
Other	417	10%
ADATSA	77	2%
ICS	9	0%
Housing	42	1%

	Number	Percent
Involuntary Commitment Services		
Referrals	281	
Unduplicated people	232	
PCN Placements	57	
Assessment Center		
Assessments, all funding	4,814	100%
ADATSA	3,272	68%
GAU	622	13%
TANF	388	8%
GA-X	272	6%
SSI	227	5%
PPW	7	0%
Other/None	26	1%
Unduplicated people	4,241	
Outpatient Treatment		
Youth		
New admissions	1,001	
Open admissions	1,416	
Unduplicated people (open)	1,292	
Open admissions by drug of choice		
Alcohol	312	22%
Opiates	8	1%
Cocaine	25	2%
Methamphetamines	55	4%
Marijuana	969	68%
Other	47	3%
New admissions by Medicaid status		
Medicaid	543	54%
Not Medicaid	458	46%
Discharges (during year)	994	
Completed treatment	334	47%
Did not complete	374	53%
Excluded from calc.	286	29%
Adult		
New admissions	3,810	
Open admissions	5,425	
Unduplicated people (open)	4,785	
Open admissions by drug of choice		
Alcohol	2,917	54%
Opiates	362	7%
Cocaine	854	16%
Methamphetamines	573	11%
Marijuana	643	12%
Other	76	1%
New admissions by Medicaid status		
Medicaid	1,371	36%
Not Medicaid	2,439	64%
Discharges (during year)	3,475	
Completed treatment	1,145	44%
Did not complete	1,468	56%
Excluded from calc.	862	25%
Opiate Substitution Treatment		
New admissions	974	
Open admissions	2,021	
Unduplicated people (open)	1,854	
New admissions by Medicaid status		
Medicaid	577	59%
Not Medicaid	397	41%

Program Comparisons

The table below shows the drug of choice data for different program areas and highlights differences among substances used.

Drug of Choice Comparison, January - December 2004

	Alcohol/Drug Help Line Calls	Detoxification Center Admissions*	Outpatient Youth Admissions	Outpatient Adult Admissions
Total Number	5,867		1,416	5,425
Drug of Choice Percentage				
Alcohol	64%		22%	54%
Opiates	7%		1%	7%
Cocaine	11%		2%	16%
Methamphetamines	4%		4%	11%
Marijuana	7%		68%	12%
Other	8%		3%	1%

*Drug of choice data for 2004 Detox admissions are not yet available.

Although not all the Alcohol/Drug Help Line (ADHL) calls are about adult use of drugs or alcohol, the fact that the majority is about adult use is consistent with the similarity in pattern between ADHL and Outpatient Adult. There is a dramatic difference between the Youth and Adult Outpatient use of marijuana.

Demographic Detail, January – December 2004

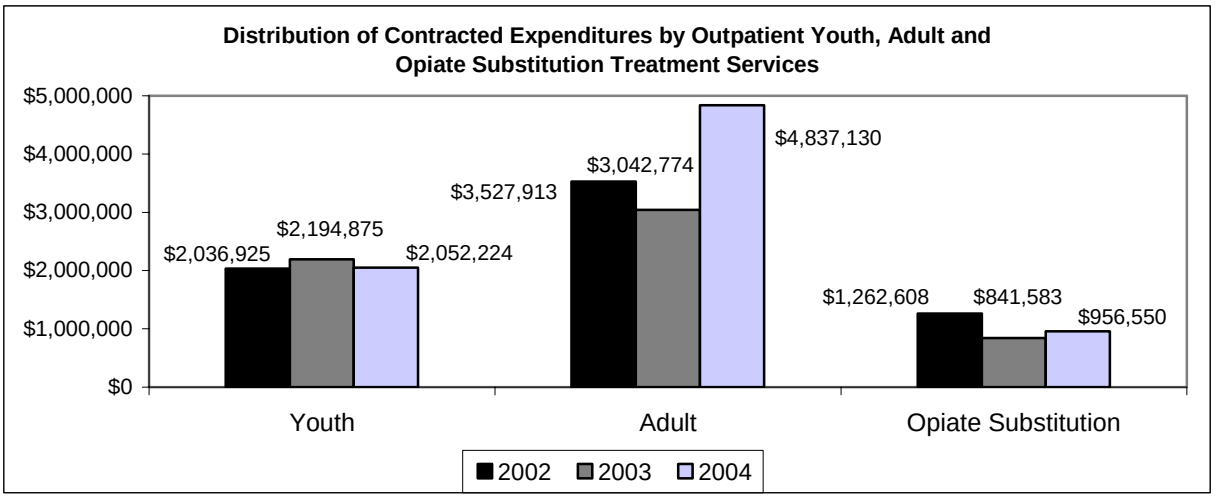
						Outpatient			King County Residents Below Fed. Pov. Level	
	Prevent.	Sobering	Detox	Ass't Ctr	ICS	Youth	Adult	Opiate Sub.	Youth (12 - 17)	Adult (over 17)
Unduplicated people served	2,959	2,245	2,770	4,241	232	1,292	4,785	1,854	11,836	104,592
Gender										
Number of people										
Male	1,163	1,935	1,998	2,738	145	887	3,146	929	5,744	46,617
Female	1,794	272	771	1,468	87	405	1,639	925	6,092	57,975
Percent of all served										
Male	39%	86%	72%	65%	63%	69%	66%	50%	49%	45%
Female	61%	12%	28%	35%	38%	31%	34%	50%	51%	55%
("Unknown gender" counts are not included)										
Race/ethnic group:										
Number of people										
African American	403	443	570	1,038	31	212	968	300	1,856	10,791
Asian/Pacific Islander	265	24	30	93	2	99	304	48	2,306	16,594
Caucasian/ White	1,732	950	1,789	2,528	164	699	2,610	1,320	5,185	63,711
Multi-racial	321	88	25	63	11	71	76	23	1,200	6,081
Native American	142	349	128	252	15	36	192	67	277	2,125
Other/ Unknown	96	391	227	267	9	175	635	96	1,012	5,290
Percent of all served										
African American	14%	20%	21%	24%	13%	16%	20%	16%	16%	10%
Asian/Pacific Islander	9%	1%	1%	2%	1%	8%	6%	3%	19%	16%
Caucasian/ White	59%	42%	65%	60%	71%	54%	55%	71%	44%	61%
Multi-racial	11%	4%	1%	1%	5%	5%	2%	1%	10%	6%
Native American	5%	16%	5%	6%	6%	3%	4%	4%	2%	2%
Other/ Unknown	3%	17%	8%	6%	4%	14%	13%	5%	9%	5%
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Hispanic origin:										
Number of people										
Hispanic origin	523	124	146	168	4	177	530	83	1,567	10,482
Not Hispanic origin/Unknown	2,436	2,121	2,623	4,073	228	1,115	4,255	1,771	10,269	94,110
Percent of all served										
Hispanic origin	18%	6%	5%	4%	2%	14%	11%	4%	13%	10%
Not Hispanic origin/Unknown	82%	94%	95%	96%	98%	86%	89%	96%	87%	90%
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

(Percentages may not add up to 100% because of rounding)

Financial Summary

King County Substance Abuse Fund
2002 - 2004 Actuals
Financial Plan

	2002 Actual	2003 Actual	2004 actual
Beginning Fund Balance	**2,135,532**	**1,264,686**	**2,848,298**
Revenues			
Licenses & Permits	0	0	0
Federal Grants	5,878,070	4,711,490	4,004,944
State Grants	8,972,371	8,630,656	9,752,532
Intergovernment Payment	233,134	148,916	167,151
Charges for Services	1,529,611	1,578,464	1,705,227
Miscellaneous	25,222	20,850	121,059
Other Financing Sources	348,118	315,070	284,015
Current Expense	1,483,696	2,630,483	2,713,696
Total Revenues	**18,470,223**	**18,035,928**	**18,748,625**
Expenditures			
Administration	(1,651,036)	(1,559,626)	(1,687,995)
Housing Voucher Program *	(3,056,206)	(515,078)	(497,691)
Treatment	(12,670,318)	(12,520,330)	(14,996,720)
Prevention Activities	(1,983,407)	(1,857,282)	(1,735,645)
Total Expenditures	**(19,360,967)**	**(16,452,316)**	**(18,918,052)**
Other Fund Transactions			
Adjustment Prior Yr Expenditures			
DCFM Energy Surcharge Refund	19,898		
Total Other Fund Transactions	**19,898**	**0**	**0**
Ending Fund Balance	**1,264,686**	**2,848,298**	**2,678,870**



* Cedar Hills Addiction Treatment Facility closed in October 2002. Subsequent expenditures are for the Housing Voucher Program.

Chemical Dependency Performance Indicators Report, Appendix A – Data Notes

This appendix describes the data sources used for the Chemical Dependency Performance Indicators Report (CDPIR) and issues around the quality, meaning and availability of the data. It also includes specific notes about the data presented for different program areas.

Data Sources and Data Quality Issues

Data Sources

The data included in this report come from four broad types of sources:

- Summary data furnished by service providers. Such data are used for Alcohol/Drug 24-Hour Help Line and Emergency Services Patrol.
- A database developed by MHCADSD that is used by the Dutch Shisler Sobering Center, Involuntary Commitment Services and the Assessment Center to collect data for those programs. Until early 2004, each of these programs used a separate Access database. All three separate databases have been replaced with an integrated chemical dependency services information system that stores data from each program in a single database accessed by separate applications for each program.
- The State DASA Prevention database, implemented in July 2003, which contains data from contracted providers about individuals who participate in multiple episode prevention programs.
- The State TARGET database, which contains data from contracted providers about individuals and their treatment services. TARGET data are used for the Detoxification Center and Youth, Adult and Opiate Substitution Outpatient Treatment portions of the CDPIR. (Although the Sobering Center and Assessment Center also submit data to the TARGET system, those data are not used in this report because only minimal TARGET data are collected for the Sobering Center and the TARGET data do not support reporting about ADATSA placements, which the MHCADSD Assessment Center database will support after the new application has been in use for a year.)

Race/Ethnicity/Hispanic Origin Data Issues:

Among the programs that are included in this report, there are a number of differences in how data about race, ethnicity and Hispanic origin are collected and/or reported. To combine the data into a single consistent format, the following decisions were made:

- The "race/ethnicity" data reported for all program areas is presented using a single set of categories.
- The categories chosen are four commonly identified broad "race/ethnicity" groups (Black/African American, White/Caucasian/European American/Middle Eastern, Asian/Pacific Islander and Native American/Alaska Native) and two other groups (Multi-racial and Other/Unknown).

Chemical Dependency Performance Indicators Report, Appendix A – Data Notes

- In those areas where the data collection system allowed more than one choice per person, any individual with data that "rolled up" into two or more different broad groups is counted as "Multi-racial" (White and Chinese, which rolled up to White and Asian-Pacific Islander, is counted as "Multi-racial"; Korean and Chinese as "Asian-Pacific Islander").
  The new MHCADSD integrated CD database allows reporting multiple ethnicities, unlike the earlier separate databases. As these are put into use, there will be a shift in the data from a single race/ethnicity to the "Multi-racial" category.
- "Other" is grouped with "Unknown" into "Other/Unknown".

Program Specific Data Notes

Prevention

Prevention data shown in the report were provided in summary form by the Alcohol, Tobacco and Other Drug Prevention (ATODP) Division of the Seattle-King County Public Health Department. Data before July 2003 are not included in this report because the data were collected in a format that does not support comparison to current data. Starting in July 2003, providers began reporting data about individuals who participated in multiple session prevention programs while reporting only the total number of participants at single event prevention activities. Data about individuals include gender, age group, ethnicity and hispanic origin.

Each multiple session program has a defined curriculum that is implemented with a registered group of participants who attend a prescribed number of sessions. Examples are Life Skills or the Nurturing Program. A single event is not an ongoing program but a prevention event that occurs once. Examples include a specific media campaign for graduation or prom time or a Health Fair.

Alcohol Drug 24-Hour Help Line

Help Line staff enter data for each call into a database. Data shown in this report are summary data for calls received during the three years in this report.

Emergency Services Patrol

The nature of this service does not support identifying individuals sufficiently to collect data on unduplicated persons.

Chemical Dependency Performance Indicators Report, Appendix A – Data Notes

Sobering Center

Data for services are entered into the integrated chemical dependency database by Sobering Center staff using the Sobering Center application. The new ability (since July 2004) to capture "multi-racial" data has resulted in some decrease in the percentage of Sobering Center multiple users who are Native American as some individuals from that ethnic group (and other groups) are now included in the multi-racial group.

Detoxification Center

Data for services at the Detoxification Center are entered into the TARGET data system by Detoxification Center staff. This report is based on downloaded data from that system.

Changes were made during 2003 in the way that Detoxification Center admissions are defined and reported. Previously, an individual who moved from one level of care to another (that is, from acute detoxification to sub-acute detoxification or from acute or sub-acute to interim chemical dependency services) was reported as having one continuous admission. Since February 2003, a separate admission has been reported for each level of care. To maintain comparability, admissions where the person had a prior detoxification admission that ended the day before the new admission date were removed from the admission totals.

TARGET requires that data about the person's self-identified drugs of choice be reported. The Detoxification Center is not required to report data about the drug(s) for which the person is receiving detoxification services.

TARGET allows multiple referrals to be reported; however, the CDPIR uses only one referral for each discharge. Discharge referrals were counted based on the following hierarchy that generally orders the choices according to the intensity of response that the referral represents: ADATSA, ITS, CD TX, Self-help, Housing and Other. ("Other" includes referrals for medical/dental, mental health and miscellaneous other resources.) Those discharges with multiple referrals are reported based on whichever of those referrals is the highest in this hierarchy. (Discharges that represent a transfer to a different level of care are excluded to remain consistent with the admission data reported.)

As noted in the report, referral data for detoxification were severely affected by changes to TARGET in 2001 and 2002. Because of significant changes in the choices for referrals on discharge and the introduction of new data collection forms and data entry screens for detoxification services, data before July 2002 cannot be compared to more recent data and, therefore, are not shown in the report.

Chemical Dependency Performance Indicators Report, Appendix A – Data Notes

Involuntary Commitment Services

Data for ICS referrals are entered into the integrated chemical dependency database by ICS staff using the ICS application. Data included are for referrals received and the disposition of each of those referrals.

Assessment Center

Data for assessments are entered into the integrated chemical dependency database by Assessment Center staff using the Assessment Center's application. Most data for this report period were converted from the previous Access database so that "multi-racial" ethnic data are just beginning to appear for Assessment Center clients.

Outpatient Treatment: Youth, Adult and Opiate Substitution

Data for all Outpatient programs are entered into the TARGET system by service providers and the CDPIR is based on those data.

The data used in this report are limited as follows:

- Only admissions where the TARGET fund source is "County Community Services" at some time during the admission are included. This fund source indicates that the services are funded with dollars King County receives from DASA or reports to DASA as required local match dollars.
- Data included for Youth and Adult are for the TARGET modalities of intensive outpatient, outpatient and MICA outpatient. Data for Youth are for all admissions where the client was under 18 on the admission date (for Adult, 18 or over).
- Data for Opiate Substitution are for all admissions where the TARGET modality is "Methadone/Opiate Substitution Treatment".
- To remove Youth and Adult admissions that are missing discharge data, any admissions that started before 2000 and have no discharge data were excluded as probable errors. (This was not done with Opiate Substitution because admissions longer than three years are common for that treatment modality.)
- Opiate Substitution admissions that were essentially transfers to another treatment location (often with the same provider) were combined. Such continuous treatment episodes were counted as a new admission only for the period when the first admission started and were counted as only one admission for any period in which the combined admissions were open.

Chemical Dependency Performance Indicators Report, Appendix A – Data Notes

The treatment completion rate is computed using the following algorithm:

$$\frac{\text{\# of discharges with treatment completed}}{\text{number of discharges}}$$

Note that the denominator used to compute treatment completion rate includes only discharges for the following reasons: completed treatment, no contact/aborted treatment, not amenable to treatment, rule violation and withdrew against program advice.

Discharges for the following reasons are excluded from the calculation of treatment completion rate: client died, funds exhausted, inappropriate admission, incarcerated, moved, transferred to different facility, withdrew with program advice, administrative closure and other.

The statewide rates for treatment completion that are cited for Youth and Adult Outpatient Treatment are based on reports from the DASA Treatment Analyzer, which contains TARGET data although it is different from the TARGET system. Those reports use the treatment completion algorithm described above. The reported results were calculated in each area (Youth and Adult) by running a statewide report and a King County report, then subtracting the numbers for King County from the statewide numbers for both the “number of discharges with treatment completed” and the “number of discharges”. The rate was then calculated as shown above.

Chemical Dependency Performance Indicators Report, Appendix B – Glossary

ADATSA	The Alcohol and Drug Addiction Treatment and Support Act, which provides state-financed treatment and support to indigent people who are chemically dependent. ADATSA provides eligible people with inpatient and outpatient chemical dependency treatment and with limited financial support for housing and other needs.
ADHL	Alcohol/Drug 24-Hour Help Line (see program description).
Biennial	Washington State's fiscal year is organized on a two-year basis, referred to as a biennium. Biennial quarters are one fourth of that period, or six months long. The current biennium began July 1, 2003 and will end June 30, 2005.
CD TX	Chemical dependency treatment.
DASA	The Washington State Division of Alcohol and Substance Abuse, a division of the Department of Social and Health Services.
ESP	Emergency Services Patrol (see program description).
GAU	General Assistance Unemployable is a Washington program that provides cash assistance to people who are incapable of gainful employment as a result of a physical or mental impairment that is expected to continue for ninety days or more. GAU recipients may be eligible for State funded treatment for chemical dependency.
GA-X	General Assistance – Expedited Medicaid provides Medicaid coverage in addition to GAU cash assistance. GA-X recipients can use Medicaid funding to pay for treatment for chemical dependency.
ICS	Involuntary Commitment Services (see program description).
MHCADSD	The Mental Health, Chemical Abuse and Dependency Services Division of the King County Department of Community and Human Services.
PPW	Pregnant and Postpartum Women is a program that provides assistance to low-income females who are pregnant or recently had a pregnancy end. PPW recipients can use Medicaid funding to pay for treatment for chemical dependency. PPW recipients have been identified by DASA as a priority population to receive services.

Chemical Dependency Performance Indicators Report, Appendix B – Glossary

SSI	Supplemental Security Income is a Federal supplemental income program funded by general tax revenues (not Social Security taxes). It helps aged, blind, and disabled people, who have little or no income, by providing monthly cash payments to meet basic needs for food, clothing, and shelter. SSI recipients can use Medicaid funding to pay for treatment for chemical dependency.
TANF	Temporary Assistance for Needy Families, which replaced "Aid to Families with Dependent Children" (AFDC) and "Job Opportunities and Basic Skills Training" (JOBS) in the 1996 federal welfare system reform. The purposes of TANF are: to provide assistance to needy families so that children can be cared for in their own homes; to reduce dependency by promoting job preparation, work and marriage; to prevent out-of-wedlock pregnancies; and to encourage the formation and maintenance of two-parent families. In Washington, TANF recipients can use Medicaid funding to pay for treatment for chemical dependency.
TARGET	Treatment Assessment and Report Generation Tool is a data collection and reporting system that is maintained by DASA and contains data about publicly funded chemical dependency treatment that are submitted by contracted treatment providers.

Chemical Dependency Performance Indicators Report, Appendix C - Program Providers for July - December 2004

Provider	Prev.	ADHL	ESP	Sober. Ctr	Detox	Ass't Ctr	ICS	Outpatient		OST
								Youth	Adult	
Alcohol & Drug 24-Hour Helpline		x								
Asian Counseling Referral Service									x	
Auburn Youth Resources	x							x		
Boys & Girls Clubs of King County	x									
Center for Career Alternatives	x									
Center for Human Services	x							x	x	
Central Youth and Family								x		
Children's Services of Sno-Valley	x									
Community Psychiatric Clinic								x	x	
Consejo Counseling & Referral Svcs	x							x	x	
Downtown Emergency Service Center									x	
Evergreen Treatment Services										x
Friends of Youth	x							x		
Girl Scouts-Totem Council	x									
Harborview Medical Center Addictions Program									x	
Kent Youth and Family Services								x		
Khmer Community Center	x									
King County Assessment Center						x				
King County Emergency Services Patrol			x							
King County Involuntary Commitment Services							x			
Neighborhood House	x									
Northshore Youth & Family Services	x									
Parent Party Patrol	x									
Perinatal Treamtent Services									x	
Recovery Centers of King County				x	x				x	
Renton Area Youth and Family Services	x							x		
Ruth Dykeman Youth and Family Services								x		
Ryther Child Center								x		
SafeFutures Youth Center	x									
Seattle Counseling Services								x	x	
Seattle Indian Health Board									x	
Seattle Mental Health									x	
Seattle Public Schools	x									
Therapeutic Health Services								x	x	x
United Indians of All Tribes								x		
Valley Cities Counseling and Consultation								x	x	
Vashon Youth & Family Services	x									
Washington Asian/Pacific Islander Families Against Substance								x		
Youth Eastside Services								x		